Prevention of falls is difficult due to the variety of circumstances involved in falls and the lack of detailed information concerning types of falls. Although falls are the second leading cause of HIAD and SCIAD in North Carolina, the possibility exists that HIADs and SCIADs from falls are considerably underreported, particularly among the elderly. Older people tend to die later after injury than younger people do (13). An injury that begins a chain of events leading to death may not be recognized as the cause of death after a period of time. Fall prevention needs to be focused on both the environment and the activities of those at highest risk. Investigation into involvement of occupation-related head and spinal cord injury resulting from falls is warranted, particularly among the nonwhite population.

Both suicide and homicide prevention involve complicated issues for which there are no easy answers. The use of alcohol has been suggested as a possible risk factor. Firearms are often involved in suicide and homicide deaths and the effects of gun control may hold promise. The effectiveness of programs to refocus and redirect hostile feelings in reducing assault have not been fully evaluated, nor have intervention programs for those identified at risk of suicide. (14)

Detailed cause of injury information is necessary for the development of effective injury prevention programs. Many fatal injuries are not specific as to cause. Better documentation of cause of injury is needed on the death certificate. The existing hospital discharge data system in North Carolina lacks cause of injury reporting as well as information concerning race. Relationships may exist between the cause of injury, the type of injury that results, and survival after injury; but this cannot be determined by comparing existing morbidity and mortality data.

Because cause of injury data were included in the collection of North Carolina Trauma Registry data (data from the eight Trauma Centers in North Carolina), a comparison of data among hospitals with and without a trauma registry was made (15). The Trauma Registry data were not representative of all North Carolina head and spinal cord injury hospitalizations. Incidence of injury differed in several respects. Patients under age 55 and males are overrepresented while those 75 and older are considerably underrepresented in the Trauma Registry. The Center for Health and Environmental Statistics is participating in a study to adjust Trauma Registry data to better reflect the injury experience in North Carolina. Until E-codes can be added to hospital discharge data, this adjusted database will serve as the source of information on cause of injury for hospitalizations.